SKYLINE Gastroenterology of West Tennessee
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PATIENT DEMOGRAPHICS INFORMATION

Please Print Legibly & Complete All Information

PATIENT INFORMATION

Last Name _____ **First Name** _____ **MI** _____

Race: [ ] Caucasian [ ] African-American [ ] Asian [ ] Hispanic or Latino [ ] Other _____

Social Security # ___-___-___ **Date of Birth (DOB)** _____ **Circle One:** Male / Female

Address _____ **City** _____ **State** _____ **Zip** _____

Cell Phone _____ **Home Phone** _____ **Work Phone** _____

Email Address _____

Preferred Method of Contact: [ ] Phone [ ] Email [ ] Patient Portal

Are You a Full-Time Student? [ ] Yes [ ] No **Are You Employed**: [ ] Full-Time [ ] Part-Time [ ] Retired

Employer Name & Address _____

Primary Care Physician _____

Preferred Pharmacy (Name & Location) _____

SPOUSE INFORMATION *(if applicable)*

Last Name _____ **First Name** _____ **MI** _____

Social Security # ___-___-___ **DOB** _____ **Circle One:** Male / Female

Cell Phone _____ **Home Phone** _____ **Work Phone** _____

Employer Name & Address _____

INSURANCE COVERAGE INFORMATION – Complete section below regarding person responsible for insurance coverage.

PRIMARY COVERAGE:

Name on Card _____ **DOB** _____ **Relationship to Patient** _____

Insurance Name _____ **SUBSCRIBER ID #** _____

SECONDARY COVERAGE:

Name on Card _____ **DOB** _____ **Relationship to Patient** _____

Insurance Name _____ **SUBSCRIBER ID #** _____

EMERGENCY CONTACT – Name of person to contact in case of an emergency, other than spouse.

Name _____

Relationship to Patient _____ **Phone #** _____

I hereby authorize payment of medical benefits billed to my insurance to Skyline Gastroenterology of West TN of West TN. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance. I understand that in the event of default in payment of any amount due and if this account is placed with a collection agency or an attorney for collection or legal action, there will be an additional charge equal to the cost of collection, including the collection agency fee, attorney fee and/or any court costs incurred. I agree to pay all co-payments, coinsurance and deductibles at the time service is rendered. I agree that any overpayment will be automatically applied for any current balance due to Skyline Gastroenterology of West TN or the Skyline Endo Surgery Center facility charge prior to a refund being given to me. I also authorize Skyline Gastroenterology of West TN to leave information regarding my care at the contact info provided above via voice or text communication.

_____ _____

Signature of Patient or Guardian *Date*

PATIENT CONSENT FOR RELEASE OF INFORMATION

I, _____, hereby authorize **Skyline Gastroenterology of West TN** to disclose my health information, which specifically identifies me, or which can reasonably be used to identify me, to carry out my treatment, payment, and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, **Skyline Gastroenterology of West TN** can refuse to treat me.

I have been informed that **Skyline Gastroenterology of West TN** has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment, and health care operations. I have the right to obtain a paper copy upon request.

I understand that I may revoke this consent at any time by notifying **Skyline Gastroenterology of West TN** in writing, but if I revoke my consent, such revocation will not affect any actions that **Skyline Gastroenterology of West TN** took before receiving my revocation.

I understand that **Skyline Gastroenterology of West TN** has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that **Skyline Gastroenterology of West TN** restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or health care operations. I understand that **Skyline Gastroenterology of West TN** does not have to agree to such restrictions, but that once such restrictions are agreed to, **Skyline Gastroenterology of West TN** must adhere to such restrictions.

I acknowledge and agree that **Skyline Gastroenterology of West TN** and any affiliate or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any phone number I have provided to you, and any other phone number associated with my account, including wireless or mobile phone numbers. I further agree that you may use any method of contact to these numbers provided, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify **Skyline Gastroenterology of West TN** if I have given up ownership or control of any such telephone number.

I acknowledge that I may be charged an appointment or procedure No Show Fee if I fail to cancel my appointment 48 hrs prior to my scheduled appointment. It is necessary for us to make appointments in order to see our patients as efficiently as possible. No Show's and late cancellations cause problems beyond a financial impact of our practice. When an appointment is made, it takes an available time slot away from another patient in need. No Show's and late cancellations delay the delivery of healthcare to other patients.

A Charge of $25 may be assessed for each No Show or late cancellation office visit appointment.

A Charge of $100 may be assessed for each No Show or late cancellation procedure appointment.

HIPAA Privacy Notice / Patient Rights / Advanced Directive

I hereby acknowledge that a copy of the Notice of Privacy Practices for **Skyline Gastroenterology of West TN** has been made available to me. I have the right to obtain a paper copy upon request.

This clinic uses secure AI-assisted dictation technology to help the provider document your visit accurately and efficiently. This technology may process spoken information during your appointment to generate clinical notes. By signing below, you acknowledge that you have been informed of the use of AI dictation and consent to its use for documentation purposes. All information remains confidential and protected according to applicable privacy laws."

I, authorize the physicians and staff of **Skyline Gastroenterology of West TN** to release information on file regarding my medical treatment and billing account to the person(s) listed below and I understand that by signing this release, the designated person(s) above will be able to speak to any member of the medical staff. Furthermore, I understand that these medical practices cannot be held liable for any information the above stated person(s) may obtain regarding my medical and billing information.

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

_____ _____

Signature of Patient or Patient Representative *Date*

_____ _____

Signature of Witness *Date*